**Critical Information Form for Center Club**

31 Bowker Street, Boston, MA 02114

617-788-1000 617-788-1080 (fax)

**Purpose**: Center Club is a rehabilitation program for men and women with a psychiatric disability.

**Eligibility**: Any person 18 years old or older with a mental health diagnosis who lives in the DMH Metro Boston Area (City of Boston, Brookline, Cambridge, Chelsea, Revere, Somerville, Winthrop) is eligible for Center Club.

**How to Request membership in Center Club**: This application form should be filled out by the applicant’s mental health provider (for example, DMH case manager, therapist, psychiatrist, residential program director, ACCS Worker). The Application should be signed by the referring person and the applicant. The attached Authorization for Release of Information should be signed by the applicant. These forms should be sent to the Center Club Intake Coordinator (US Mail, fax or email).

**Date**

**Last Name First Name**

**Address**

**Date of Birth Telephone**

**Gender Language Preference**

**Are you a veteran? Yes No**

**Are you a registered voter? Yes No**

**Mental Health Providers**

Name/TitleTelephone

Agency/Address

Name/TitleTelephone

Agency/Address

**ACCS Provider**

Name/TitleTelephone

Agency/Address

**Other Service Providers** (e.g., MRC, Housing, Probation, PACT, Peer Operated Services):

Name/TitleTelephone

Agency/Address

Name/TitleTelephone

Agency/Address

**Referred by** Telephone

Title

Agency

Address

**Social Security #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you a DMH client? Yes No**

**If you are, please check the DMH site where you get services:**

|  |  |
| --- | --- |
| **√** | **DMH Site** |
| ☐ | Lindemann/Cambridge-Somerville Site (BLS) |
| ☐ | Massachusetts Mental Health Center Site (BMS) |
| ☐ | Fuller/Bay Cove Site (BFS) |

**Reasons for Referral to Center Club:**

|  |  |
| --- | --- |
| **√** | **Reasons for Referral to Center Club** |
| ☐ | Education |
| ☐ | Employment |
| ☐ | Health and Wellness |
| ☐ | Housing |
| ☐ | Peer Support |
| ☐ | Socialization |
| ☐ | Life Skills (specify) |
| ☐ | Access other community services |

|  |  |  |
| --- | --- | --- |
| **Date of Diagnosis:** | | **Clinician (please print and sign):** |
| **Axis I** |  | |
|  |  | |
| **Axis II** |  | |
|  |  | |
| **Axis III** |  | |
|  |  | |
| **Axis IV** |  | |
|  |  | |
| **Axis V** |  | |
|  |  | |

**Medication (psychiatric)**

(Attach extra sheet if more space is necessary)

|  |  |  |
| --- | --- | --- |
| **Name of Medication** | **Dose** | **Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Medical (non-psychiatric):**

**Non-psychiatric Medical Problems**

**Medication (non-psychiatric)**

(Attach extra sheet if more space is necessary)

|  |  |  |
| --- | --- | --- |
| **Name of Medication** | **Dose** | **Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Primary Care Physician**  **Telephone**

**Address**

**Name of Emergency Contact or Legally Authorized Representative (LAR):**

**Name Relationship**

**Address Telephone**

**Risk Assessment**

This page should be filled out by the applicant together with the referring person.

Applicant’s Name

Assessment completed by

**Situations of Risk (please check all that apply):**

Center Club is rehabilitation program. We strive to promote peer support and independence. This is the reason why Center Club is not a staff intensive program. We want to be a welcoming program for all adults experiencing a psychiatric disability. We believe that a person should have the chance to move on towards rehabilitation even if they have had very difficult experiences in the past. At the same time it is important that the whole clubhouse community feel safe at the club. We depend on each member being able to interact with others in a way that fosters a feeling of safety for all.

***Please do not leave this page blank.***

**1. No situations of risk** **☐**

**2. Situations of risk:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **√** | **Situations of Risk** | **Description** | **Past Problem (date)** | **Problem within past two years** |
|  | Aggressive/Assaultive Behavior |  |  |  |
|  | Homicidal Behavior |  |  |  |
|  | Problematic Sexual Behavior |  |  |  |
|  | Involvement with the Criminal Justice System |  |  |  |

**If the applicant has had a past or a current problem with any of the behaviors listed above, or if the applicant has a current or past involvement with the criminal justice system,**

***please attach a written account of the problematic behaviors or involvement with the criminal justice system (include contact information for probation or parole officers).***

Center Club is a rehabilitation program and not a clinical program. And yet occasions arise when it is helpful for us to know some things about a person’s experiences that may put them at risk.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **√** | **Other Situations of Risk** | **Description** | **Past Problem (date)** | **Problem within past two years** |
|  | Auditory/Visual Hallucinations |  |  |  |
|  | Suicidal Ideation/Attempt |  |  |  |
|  | Substance Abuse (specify) |  |  |  |

**Comments:**

**Applicant’s Signature**

**Service Provider’s Signature**

**Center Club**

**a program of**

**Bay Cove Human Services**

**AUTHORIZATION FOR RELEASE OR REQUEST OF INFORMATION BETWEEN CENTER CLUB STAFF MEMBERS AND MEMBERS OF THE REHABILITATION/TREATMENT TEAM**

I authorize Center Club to obtain information from, forward my confidential records or hold general discussions about my rehabilitation/treatment with members of my treatment/rehabilitation team.

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ This consent is valid for one year from this date

**Rehabilitation/Treatment Team Members (for example, therapist, psychiatrist, residential program director, ACCS worker)**

|  |  |
| --- | --- |
| **Name and Title** | **Agency** |
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Member/Guardian Signature Date Please Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Florence Mugenyi- Intake Coodinator

Signature of Person Date Please Print Name and Title

Obtaining Authorization